印度的服務業貿易：以健保為例

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中文摘要

除了個人平均所得之外，健康與人類發展對一國整體的社會經濟發展而言是密不可分的。在過去的六十多年裡，由於現代醫藥普及，印度的健康體系已有相當的改善，尤其是在壽命（life expectancy）與嬰兒夭折率（infant mortality rate）這兩項健康狀況指標。但是，這兩項成就在印度各邦之間卻有很大的差距。另一項事實是印度增加健康醫療普及的速度的確很慢。這很大一部份與嚴密管理的國家化健康保險業有關。

本文主旨是討論開放保險業市場將如何會促使印度的健康醫療擴及貧民以及如何會改善與強化印度向世界行銷醫療觀光與病患照顧的人力資源的優勢。

India's Services Trade: Focusing on the Health Insurance Sector

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Key words: India, Trade in services, health care industry, Medical Service Exports

Abstract

Health and human development, in addition to per capita incomes, form an integral part of the overall socio-economic development of a nation. The health system in India has improved during the past six decades with the spread and accessibility of modern medicine and considerable improvements in two important indicators of health status, life expectancy at birth and the infant mortality rate. In terms of life expectancy, child survival and maternal mortality, India's performance has improved steadily. However there are wide divergences in the achievements across states. However, what is also true is that India's attempts at accelerating the pace of access to Health care are indeed slow. And much of this is on account of the severely regulated and nationalized health insurance sector. This paper looks at how an opening up of the insurance sector will enable India to increase health care access to the poor and better leverage its strength in human resources to market health tourism, healthcare and patient care to the rest of the world.

Overview

Healthcare has emerged as one of the largest service sectors in India. In 2010, national healthcare spending equaled about 5.5 per cent of nominal GDP, or about US$ 34.9 billion. Healthcare spending in India is rising by 12 per cent per annum through 2005-12 and is expected to scale up to about 6.5 per cent of GDP, or US$ 70 billion. Other estimates suggest that by 2012, healthcare spending could contribute 8 per cent of GDP and employ around 9 million people.

Healthcare Industry

The Indian health-care delivery market is nearly US $18.7 billion, growing annually at the rate of 13 to 15 percent. The strong Indian middle-class acts as a prime driver of growth of health-care facilities in the country. Changing demographic and socio-economic profile of the population in favour of the youth, and changing lifestyle patterns are opening unprecedented demands for preventive and curative health-care facilities. The healthcare industry in India, which comprises hospital and allied sectors, is projected to grow at 23 percent per annum to touch Rs. 312,000 crore by 2012 from the current estimated size of Rs. 168,000 crore. The sector has registered a growth of 9.3 percent between 2000-2009, comparable to the sectoral growth rate of other emerging economies such as China, Brazil, and Mexico. Growth in the sector is driven by healthcare facilities, private and public sectors, medical diagnostics and pathological laboratories, and the medical insurance sector.

The Indian medical equipment and devices market is estimated at Rs. 14,375 crore in 2009 with a consistent growth of 15 percent per annum. Market for medical supplies and disposables is dominated by the domestic manufacturers, whereas imported brands dominate the premium and high-end medical equipment market. The Indian medical equipment and devices market is on the growth radar of several multinational companies, and imports are expected to increase. Driven by increasing awareness and affordability coupled with an increasing patient pool, the market is forecast to grow by 12 percent annually for the next five years to reach Rs. 28,370 crore in 2015.

From a pan-India perspective, presently there are more than half a million doctors employed in 15,097 hospitals. Additionally there are 0.75 million nurses, who look after more than 870,000 hospital beds. During the previous decade, the number of doctors has increased by 36.6 per cent. An estimated 30 per cent of medical practitioners hold specialist qualifications.

According to government estimates, 30000 doctors pass out every year from the 266 medical colleges in India, including private colleges. A majority work in urban areas, a few migrate and very few are those who devote themselves to rural populations. As a result, while there are nearly 7 lakh doctors registered in India, most of them in urban areas and only around 22000 in rural areas. It is not surprising therefore that rural health care is in shambles.

Public and Private Provision of Healthcare

The government sector accounts for 18% of the overall spending (0.9% of GDP) whereas the private sector accounts for 82% of the overall health expenditure (4.2% of GDP). It is estimated that India requires another 1.75 m beds by 2025. It is also forecast that the public sector will only be able to contribute about 15 per cent of the required $86 b investment.

Estimates show that more than eighty per cent of India's population accesses private health care that is often very expensive and of dubious quality. The situation is particularly tragic because the single biggest contributor to chronic poverty in India is expenditure on health care, and various estimates have shown that more than a quarter of those who remain below poverty line for more than 5 years are there because of the costs of healthcare.

Need for Risk Mitigation

Vulnerability is both a cause and a symptom of poverty. It resides in the many shocks that pervade the lives of the poor. The frequent occurrence of these shocks can easily erode hard won gains and force households quickly back into poverty.[1] Over the past few years, a growing body of evidence[2] shows that microfinance has had a positive impact on the poor. Growth of enterprise revenues and, in turn, increased household incomes have

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1 World Bank; *Investing in Health.* World Development Report 1993. New York: Oxford University Press for the World Bank.

2 Miller, M; Northrip, Z; *Bamako 2000: Innovations in Microfinance, 2001.*

brought important benefits to many households. However, focusing only on static measures of household earnings and income tends to mask the more dynamic side of poverty, the vulnerability of the poor to risk.

Risk comes in many forms, for example, illness, death, fire or theft. These risks could occur frequently and create financial pressures that exacerbate the ever-present stress of meeting regular needs such as food, rent and school fees. To cope with risk the poor use a diversity of strategies. These include borrowing, saving, selling productive and non-productive assets, and other forms of 'self-insurance', informal group-based risk sharing systems, and, occasionally, formal insurance. Yet, the effectiveness of these strategies is limited. Factors such as lack of timeliness, limited coverage and high costs suggest an insurance landscape that is far from perfect. In addition, poverty impedes many from taking risks and gaining access to what is on offer.

In the absence of insurance, the poor often avoid risky but potentially profitable economic activities and enter into informal insurance arrangements or rely on precautionary savings. It has been found that the largest gap between demand and access for the rural people is for insurance. The vulnerability of the poor farmer with regard to risks faced especially of health and illness is intense and therefore it is a pity that appropriate health insurance schemes are not available for the poor in India. With a population of over 1 billion growing at the rate of approximately 2 percent every year, India presents immense opportunities for investment in the health care

sector. The sheer size of the existing health-care infrastructure in India gives an idea of the growth potential that this sector offers to domestic and foreign investors. With more than 15000 hospitals, 500,000 doctors, 737,000 nurses, 170 medical colleges and 350,000 retail chemist outlets, Indian health-care sector is by far one of the largest in the world.

Health Infrastructure	
Hospitals (public & private)	15000
Doctors	500,000
Nurses	737,000
Medical Colleges (public and private)	170
Retail Chemist Outlets	350,000

Source: ICRA

Less than 10% of the Indian population is covered by some form of health insurance. It is expected that the major international players will establish networks of affiliated hospitals and seek direct involvement in the development of new facilities. The voluntary health insurance market is expected to grow fast with estimates of Rs. 130 billion by 2005. Privatisation of Insurance will extrapolate into a new healthcare delivery system in India. Currently, only 2 million people – which is 0.2 per cent of the total population – are covered under Mediclaim with estimates that there are 315 million potentially insurable lives in the country. Insurance companies estimate that with health insurance coming in, 6 per cent of household income will be spent on healthcare up from the current 2 per cent.

India has made significant progress in the past several decades in improving the health and well-being of its people. Over the past years, life expectancy has risen by 17 years to 61 years, and infant mortality has fallen by more than two-thirds to 74 deaths per 1,000 live births.[3] Despite these significant strides, the country continues to bear a heavy burden of both communicable and non-communicable diseases. Furthermore, India is experiencing a slow epidemiological evolution from infectious and parasitic diseases to non-communicable diseases. Also, the emergence of AIDS has begun to affect national and regional epidemiological profiles and priorities.

The government has sought to help states to improve their health policy environment and access to quality of services, with particular attention to building institutional capacity, the first-referral level, and services for the poor. This will help in establishing sustainable health systems that focus on cost-effective programs, and also make sufficient use of the private sector. The priority will be to develop effective and sustainable health systems that can meet the dual demands posed by the growth in non-communicable diseases and peoples' needs for better quality and higher levels of health care. Government sector that provides publicly financed and managed

[3] Life expectancy is now 63.5 years, infant mortality rate is now 53 per 1000 live births, maternal mortality ratio is down to 254 per lakh live births and total fertility rate has declined to 2.6. However there are wide divergences in the achievements across states. There are also inequities based on rural urban divides, gender imbalances and caste patterns and importantly literacy rates.

curative and preventive health services from primary to tertiary level, throughout the country and free of cost to the consumer (these account for about 18% of the overall health spending and 0.9% of the GDP).

The private sector plays a dominant role in the provision of individual curative care through ambulatory services and accounts for about 82% of the overall health expenditure and 4.2% of the GDP. Nationwide health care utilization rates show that private health services are directed mainly at providing primary health care and financed from private resources, which could place a disproportionate burden on the poor. Most of these costs are out of pocket costs, State governments contribute 15.2%, central government 5.2, and third-party insurance and employers put in 3.3% of the total.[4] Private sector has 70% specialists and 85% of technology in their facilities. It account for 49% beds and occupancy ratio of 44%, where as occupancy rate in public sector is 62%. More than 75% of service delivery for dental health, mental health, orthopedics, vascular and cancer diseases and about 40% of communicable diseases and deliveries are provided by the private sector.

The provision of health care by the public sector is a responsibility shared by state, central and local governments, although it is effectively a state responsibility in terms of service delivery. State and local governments incur about three-quarters and the center about one-quarter of public spending on health. The responsibility for

[4] Ramesh Bhat and Nishant Jain, "Analysis of Public and Private Healthcare Expenditures," *Economic and Political Weekly*, vol. XLI, no.1, 2006, pp. 57-68.

health is at three levels. First, health is primarily a state responsibility. Second, the center is responsible for health services in union territories without a legislature and is also responsible for developing and monitoring national standards and regulations, linking the states with funding agencies, and sponsoring numerous schemes for implementation by state governments. Third, both the center and the states have a joint responsibility for programmes listed under the concurrent list. Goals and strategies for the public sector in health care are established through a consultative process involving all levels of government through the Central Council for Health and Family Welfare.

Risk Assessment

It was once assumed that poor people had no need for financial services, and perhaps needed only credit. Yet the conditions under which the poor live suggest otherwise. For poor people, risk is familiar and high. Strategies for managing and coping with risk are part of everyday life. Research[5] and experience have shown that the poverty and uncertainty poor people face require diverse financial services. Borrowing helps households achieve food security and alleviate poverty. In times of stress, the poor need to borrow to pay for essential consumption. But borrowing alone is not enough to pull households out of poverty. Poor people also require savings services to help them better manage their resources over time and to enable them plan and finance their investments. And most

[5] Freiberg, J; *Social Security for the Poor – Options and Experiences*, 1999.

importantly, the poor need access to insurance to lessen the blow when, for instance, a breadwinner falls ill, crops fail, or prices for their products plummet.

Types of Risks

- ***Life Cycle Needs***

Low-income households are most commonly exposed to expenditure requirements for life cycle needs, such as paying for a child's education, re-stocking household supplies, paying a sufficient dowry, or saving for retirement. These needs arise when flows of income do not coincide with required expenditures. While households are generally aware whether and when these events will occur, the high likelihood and frequency of their occurrence create an on-going uncertainty as to whether the household will have sufficient income or assets to cover the cost associated with these events. While individually these events have the least severe impact, their frequency makes managing them a pressing need for many low-income households.

- ***Death Risks***

Death risks include the costs that result from the death of a family member. The degree of uncertainty regarding death is greater than that caused by life cycle events, but less than that caused by most other risks faced by low-income households. This is because family members are sure that they will at some point die. However they experience uncertainty regarding when this

may happen. The loss a household experiences when a death occurs (apart from the emotional loss) includes both a one-time component (e.g., cost of proper burial, cost of settling the deceased's accounts, etc.) and, potentially, an ongoing component to replace income that the deceased formerly provided to the family.

- ***Property Risks***

Property risks include events leading to theft, damage, loss, or destruction of a household asset. Crop losses, livestock illness or death, and fire, are all examples of the types of asset losses that low-income households may need to protect against. Given the range in value of these assets and the situation specific nature of property risks (i.e., the likelihood of theft varies substantially by community), the impact of property risks will vary by family and locality. In general, property risks are likely to cause households greater uncertainty than death risks or lifecycle needs because they cannot be sure whether, when, or how often a fire or theft might occur. The relative value of a household's loss due to a property risk will depend on the asset at risk.

- ***Health Risks***

Besides life cycle needs, health risks—accidents, illnesses, and injuries that require households to pay for medical treatment—are among the most common concerns of low-income households. The cost to a household of each accident, illness or injury is generally one-time and, like property risks, can vary from relatively

small, such as purchasing aspirin, to relatively large, such as major surgeries. The frequency with which health risks can occur, and the household's limited ability to predict whether or when they will be affected, suggest that health risks generate a greater degree of uncertainty than other risks.

- ***Disability Risks***

The causes of disability risks are essentially the same as those for health risks (accidents, illnesses, and injuries), however there is a greater relative cost to a household of having a family member disabled than injured or sick. A disabled family member may require ongoing treatment expenses besides the cost of the initial medical attention. Households may also incur additional costs in replacing lost income if the family member is no longer able to work. This is especially problematic if the disabled family member is young. Instead of becoming a future source of income for the family, her disability requires an on-going expense. Consequently, when these risks occur, low-income households have greater difficulty overcoming disability risks than health risks.

- ***Mass, Covariant Risks***

Mass, covariant risks are the threat that an event, such as an epidemic, a natural disaster, and war, could cause substantial losses for a large portion of a population at the same time. These risks could fit into the categories described above based on the impact they have on households. Death, property damage, illness, and

disability are all associated with mass, covariant risks.

Mass, covariant risks are considered separately [6] because:

(1) They tend to be difficult or impossible to predict;
(2) They affect many people at the same time, thus hampering the ability of risk-pooling mechanisms to protect against these risks; and
(3) The cost associated with mass, covariant risks tends to be significantly greater than that resulting from other risks. This is because households are forced to deal with multiple losses at the same time (e.g., severe flooding leading to death of a family member, destruction of the family's home and several injuries to remaining family members); and a households' traditional risk coping strategies, such as intra-family gift giving, reciprocal exchange and non-financial savings tend to be weakened or destroyed because neighbors and local family members are suffering the similar losses at the same time.

Why Health Insurance?

Insurance protects against unexpected losses by pooling the resources of the many to compensate for the losses of the few. The greater the uncertainty of the event the more insurance becomes the economical form of

[6] Miller, M; Northrip, Z; *Bamako 2000: Innovations in Microfinance, 2001*.

protection. Insurance replaces the uncertain prospect of large losses with the certainty of making small, regular, affordable premium payments. The primary function of insurance is to act as a risk transfer mechanism, to provide peace of mind and protect against losses.

Insurance is not the only way of dealing with risks, and not all risks are insurable[7]. However, health risks such as those relating to illness, injury, disability, maternity and the like are considered to be eminently insurable as these risks are mostly independent or idiosyncratic, that is, not correlated among community members[8]. Moreover, among several risks facing poor households, health risk is considered to be crucial as it has a destabilizing effect on household finances: directly, by thrusting health expenditure in the event of illness and indirectly, by affecting the income earning capacity of households. [9]

Health insurance enables access to better medical services and a longer and better quality of life. Thus, access to adequate insurance protection can assist the poor to achieve sustainable growth and provide them with the capability to attain a better standard of living. It can mitigate the impact of personal and environmental

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7 Brown, W; Churchill, C; *Providing Insurance to Low-Income Households*, USAID, 1999.

8 Alderman and Paxson. (1994). "*Do the Poor Insure*?" A Synthesis of Literature on Risk and Consumption in Developing Countries. In Bacha (ed.) Economics in a Changing World: Vol. 4: Development, Trade and the Environment. Macmillan Press, London, England.

9 Asfaw, A., von Braun, J., Assefa Admassie, A., & Jütting, J; The Economic Costs of Illness in Low Income Countries: The Case of *Rural* Ethiopia." Mimeo.

calamities on the build-up of assets and provide escape from the vicious circle of poverty. Insurance can also protect those that have risen above the poverty level against unforeseen events that may cause them to fall back into poverty.

For most people living in developing countries “health insurance” is however an unknown word. It is generally assumed that, with the exception of the upper classes, people cannot afford such type of social protection. This is unfortunate, as poor people need protection against the financial consequences of illnesses. Illness still represents a permanent threat to their income earning capacity. Beside the direct costs for treatment and drugs, indirect costs for the missing labor force of the ill person have to be shouldered by the household.

Health insurance schemes are an increasingly recognized factor as a tool to finance health care provision in low-income countries. Given the high latent demand from people for health care services of a good quality and the extreme under-utilization of health services in several countries, it has been argued that social health insurance may improve the access to health care of acceptable quality. Whereas alternative forms of health care financing and cost recovery strategies like user fees have been heavily criticized, the option of insurance seems to be a promising alternative as it is a possibility to pool risk transferring, unforeseeable health care costs to fixed premiums. Recently, mainly in Sub-Saharan Africa but also in a variety of other countries, non-profit, mutual, community-based health insurance schemes have

emerged. These schemes are characterized by an ethic of mutual aid, solidarity and the collective pooling of health risks. In several countries these schemes operate in conjunction with health care providers, mainly hospitals in the area.

Community Based Health Insurance (CBHI)

Community based health insurance is seen as an effective way in financing health care costs. Health insurance by pooling of risks across members who participate in health insurance lessens the financial burden of members affected by illness. Indeed, several types of community based health insurance schemes have emerged in Sub-Saharan Africa, [10] Asia and in other regions[11]. Community health care financing schemes are usually based on the following characteristics: voluntary membership, non-profit objective, link to a health care provider (often hospital in the area), risk pooling and relying on an ethic of mutual aid/solidarity.

Benefits

The real benefit of CBHI lies in keeping the transaction costs low, in the design of schemes suited to the community needs, in influencing health behavior

[10] Wiesmann, D., & Jütting, J. (2000). *The Emerging* Movement of Community Based Health Insurance in Sub-Saharan Africa: Experiences and Lessons Learned. Afrika Spectrum, 2/2000, p. 193 – 210.

[11] Bennett, S., Creese, A., & Monash, R. (1998). *Health Insurance Schemes for People Outside Formal Sector Employment*. ARA Paper No. 16, WHO, Geneva。

through health education, and in influencing the supply of health care. Its advantage lies in being able to reach low-income people in rural areas and working in the informal sector who are otherwise difficult to reach, to exploit social capital in bringing about greater awareness, correct adverse selection and moral hazard problems, encourage preventive measures and increase access to health care. Popularizing insurance among low-income people requires conveying the idea, canvassing for it, collecting premium, and verifying claims and then reimbursing these claims, thus incurring high costs. In case of formal providers, all these functions typically take up a significant part (at least 20 per cent) of the premium amount. In CBHI schemes such costs can be kept low, say to 5-6 per cent. This is because many of these tasks can be performed by the community members themselves.

Besides, in poor communities, the financial barrier is only one of the barriers to accessing health care. Often, there are many non-financial barriers that must also be overcome through the design of schemes, which ought to take into account characteristics of the community. All these aspects can best be handled if the scheme is community based. Additionally, the problems of adverse selection and moral hazard that arise due to informational asymmetries too can be reduced by making use of local knowledge that is readily available among people living in close communities.

Limitations

Community based schemes also have certain weaknesses such as low capital base, low level of revenue

mobilization, frequent exclusion of the poorest of the poor, small size of risk pool, limited management capacity, and isolation from more comprehensive benefits. Some forms of CBHI also have important limitations[12]. For example, where an NGO itself provides insurance (acts like an insurer) the ability of the NGO to have a pool of well diversified risk is limited. This in turn restricts the ability of NGO to cover or insure variety of risks facing the target population. Moreover, where CBHI schemes are critically dependent on external funding, extending the reach of these schemes then depends on the amount of such funding available. Furthermore, the insurance schemes launched either by national or state-level governments when elections are in sight tend to be populist or vote-catching ploy. Since such schemes have to be renewed every year, these tend to be dropped once the elections are over. It is to be seen if the universal health insurance scheme belongs to this category.

A few micro-level studies that have tried to estimate demand for health insurance based on the willingness-and- ability-to-pay for health insurance have come out with positive findings. A survey-based study on the willingness to pay even in case of Ethiopia - one of the poorest countries in the Sub-Sahara Africa - shows that the poor are willing to pay up to 5 % of their monthly income for a scheme that can take care of their costs of illness.[13]

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[12] Gumber, A; "*Hedging the Health of the Poor – The Case for Community Financing in India"*, 2001.

[13] Asfaw, A., von Braun, J., Assefa Admassie, A., & Jütting, J. "*The Economic Costs of Illness in Low Income Countries: The Case of Rural Ethiopia"*. Mimeo

Health Insurance for the Poor in India

Health insurance for the poor in India is still very much in the nascent stage. It takes different forms, being either community-based (CBHI) or noncommunity-based (like Jan Arogya policy of the government). The Community Based Health Insurance (CBHI) can itself take several forms.[14]

Community and self-generated financing programmes are those usually run by non-governmental organizations (NGOs) or non-profit making organisations. [15] These organisations rely on finances from various sources, including government, donor agencies, and community and self-generated sources. Also many innovative methods of financing health care services have been used, like progressive premium scales, community-based pre-payment/insurance schemes, and income-generating schemes. The target population for provision of health care services by such organisations is primarily workers and families outside the formal sector. The sources of revenue for the programmes can be categorized as:

(a) User fees defined as the payment made by the beneficiaries directly to the health care provider, such as fees for services or prices paid for drugs/immunization. This mode of financing is not common.

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[14] Gumber, A; "*Hedging the Health of the Poor – The Case for Community Financing in India"*, 2001.

[15] Dave, Priti; "*Community and Self-Financing in Voluntary Health Programs in India*", Health Policy and Planning, Vol.6 (1)

(b) Prepayment/insurance schemes, including payment by members for drugs either at subsidized rate or at cost price.

(c) Commercial schemes for-profit actively run by organisations to finance health care.

(d) Fund raising activities by organisations for financing health care services. In some cases the revenue raised in this manner constitutes more than 5 per cent of the total funds of the organisations.

(e) System of making contributions in kind (such as rice, sorghum, community labor, etc.). This method is not very popular due to difficulty in management.

(f) Other sources of community-based and self-financing include instances like Tribhovandas Foundation providing health care through village milk cooperatives and Amul Union (the milk cooperative organization) contributing significantly towards health services through putting a cess on milk collection.

All these forms currently exist in the country but only in small pockets, depending on the local conditions that vary considerably across regions. The most pertinent point about these schemes is their rural orientation and ability to mobilize resources in a village community. However, most of these schemes have catered to a small section of population with limited health coverage restricted to elementary, preventive, and maternal and child health (MCH) care. CBHI schemes are designed in a number of ways, depending on the socio-economic characteristics of the target population, health profile of the population, and the health risks prevalent in the region. The decentralization process initiated in the country with

the 73rd and 74th Constitutional Amendment aimed at promoting local bodies (Panchayati Raj Institutions (PRIs) in the rural areas and Nagar Palikas in the urban areas) has raised hopes of being able to reach the poor through community based initiatives with some subsidy to those who cannot afford the costs.[16]

Investments in Healthcare

Hospitals and diagnostic centers have received FDI worth Rs. 3650 crore between April 2000 and January 2010. Healthcare major, Fortis Hospitals has planned to invest Rs. 260 crore, to expand its facilities pan-India. Asia's one of the leading hospital chains, Columbia Asia Group, which already has six hospitals in the country, also has planned to ramp-up its operations in India by opening eight more multi-specialty community hospitals with a total capacity of 800 beds by mid-2012. The group has earmarked a total investment of Rs. 800 crore for the 14 hospitals.

The Government launched the National Rural Health Mission (NRHM) in 2005. It aims to provide quality healthcare for all and increase the expenditure on healthcare from 0.9 percent of GDP to 2-3 percent of GDP by 2012. During the 2009 interim budget, the government hiked the allocation for NRHM by Rs. 2050 crore over and above Rs. 12,000 crore. Moreover, the government

[16] Gumber, A. and V. Kulkarni. Paper presented in the National Consultation on Health Security in India Organized by Institute for Human Development and UNDP with support from Ministry of Health and Family Welfare, Government of India, July 26-27, 2001.

announced a Rs. 300 crore initiative in October 2009 to promote domestic manufacture of medical devices such as stents, catheters, heart valves, and orthopedic implants that may lead to lower prices of these critical equipment. In order to meet revised cost of construction, in March 2010 the government allocated an additional Rs. 6000 crore for six upcoming AIIMS-like institutes and upgradation of 13 existing government medical colleges.

With increased plan allocation for Ministry of Health and Family Welfare from Rs. 19,534 crore in 2009-10 to Rs. 22,300 crore in 2010-11, Budget 2010-11 is overall positive for the economy and should help sustain the recovery that is currently underway. While other sectors have seen an increase in excise duty, the medical equipment sector has been spared. Additionally, the existing multiple rate and complex import duty structure has been replaced by a uniform low import-duty rate of 5 percent, countervailing duty of 4 percent, and exemption from special additional duty.

To encourage domestic manufacturing, while parts for manufacturing medical equipment will attract a 5 percent import duty, there will be no countervailing duty and special additional duty. Orthopedic implants continue to have zero import duty and to protect local manufacturing specified inputs used for manufacturing; orthopedic implants have now been exempted from import duty. But, at 0.36 percent of the gross domestic product or 2.3 percent of the total budget expenditure for the financial year 2010-11, India's annual healthcare spend continues to remain one of the lowest in the world. India has been

consistently increasing the allocation for the healthcare of its over 1.2 billion population over the years. Despite these efforts the spending for healthcare remains a minuscule. Health expenditure in India still remain an out of pocket spend for the people as the government allow no insurance schemes for the welfare of patients. Some of the states governments, however, have made some efforts to improve healthcare by allocating more for the health sector, at around 4 per cent of the total budget expenditure.

The greater reliance on private delivery of health infrastructure and health services means that overall these will be socially underprovided by private agents, and may also deny adequate access to the poor. The healthcare delivery system is under pressure to identify and commercialize simple medical solutions quickly to lower costs, control infections, reduce liability, and eliminate preventable errors. This demand along with the trend toward more user-friendly healthcare products may spur the demand for innovative medical equipment.

Health Insurance Market

Indian health insurance market has emerged as a new and lucrative growth avenue for both the existing players as well as the new entrants. The health insurance market represents one the fastest growing and second largest non-life insurance segment in the country. It has posted record growth in the last two fiscals (2008-09 and 2009-10). Moreover, the health insurance premium is expected to grow at a CAGR of over 25 percent for the period spanning from 2009-10 to 2013-14. The medical

insurance sector may account for Rs. 14,500 crore in the next three years, up from the estimated current size of over Rs. 5000 crore. India offers tremendous opportunity for private medical insurance players. Increasing awareness levels and large-scale group insurance policies have pushed growth in the health insurance segment in recent years.

In the year 2004-05, while the four public sector players collected a health insurance premium of US$ 317.3 million registering a growth of 24 per cent over 2003-04, the eight private players collected a total health premium of US$ 67.6 million, growing by a phenomenal 148 per cent.

Health insurance is a rapidly growing market in India.[17] The number of lives covered under health plans has improved from 4-5 million about six years back to over 15 million today. With benefits being offered to private players in the health insurance market, a number of international insurers are making their presence felt in India.

[17] Health insurance premium is set to touch US$ 1.2 billion by the end of 2011 as against US$ 385 million in 2004-05, primarily due to growing awareness. With escalating medical costs, companies are already looking at the option of increasing the premium by about 15 per cent to 20 per cent for health insurance.

Health business across various insurers during (2004-2005)

Insurer	Health premium (In Rs. Crores) 2004-05	Health premium as percentage of total non-life business 2004-05	Growth of Health premium (2003/04-2004/05) (%)	Growth of total premium (2003/04-2004/05) (%)
ICICI Lombard	118.78	13.4	257.0	74.7
Bajaj Allianz	70.93	8.3	242.2	79.0
Royal Sundaram	30.02	9.1	88.8	28.5
IFFCO-Tokio	28.37	5.6	73.3	56.0
Tata AIG	26.64	5.7	35.3	32.7
Cholamandalam	20.12	11.8		75.3
Reliance	7.98	4.9	2.4	0.3
HDFC Chubb	1.97	1.1		59.2
Private sector	304.27	8.6	148.0	55.3
New India	504.28	11.9	43.9	4.5
National	364.29	9.5	26.3	11.9
United India	294.19	10.0	5.2	-3.8
Oriental	265.19	8.7	13.9	5.9
Public sector	1,427.9	9.8	24.0	5.2
Total	**1,732.17**	**9.6**	**36.0**	**12.3**

Source: Express Healthcare Management, Issue dated September 2005

Source: Express Healthcare Management, Issue dated September 2005

Along with offering general insurance, Iffco Tokio has made an entry into the health insurance market. Chubb is another entrant into India. It has formed an alliance with HDFC for offering health insurance. Miliman is the latest multinational to make a foray into the Indian health insurance sector. A large number of companies are also waiting in the wings to make a foray into the market, including leading global players such as Aetna, Brooke

Shield, and Blue Cross, among others.[18]

Shifting stands – India at the WTO

India has been a steadfast votary of multilateralism even when it was at a socialist economy nationalizing its various sectors. Even now, while it continues to be a relatively high tariff country with restrictions on a number of sectors, it leads the small pack of countries that prefer a multilateral institution to bilateral and plurilateral agreements. However, every now and then, the Indian position seems to shift. With each debacle at the WTO, a flurry of talks start, with important trading partners, for bilateral free trade agreements. Every two years or so, India starts talking aggressively for a stronger and healthier South Asian Free Trade Agreement. That is why in the last meeting at the WTO, India's position looked strange and was more of posturing against the developed world than a substantial argument on trade issues.

At times, India aspires to lead the pack of poor countries protesting at the WTO and then finds out that this leadership is costly especially when it does not consider itself a poor or developing country any more. India was opposed to liberalization and tariff reduction in non agricultural goods a while ago, now argues strongly

[18] In order to spur the private health insurance sector, the Insurance Regulatory & Development Authority (IRDA) has increased the FDI limit from 26 per cent to 51 per cent. It has further reduced the minimum capital requirement to US$ 11.1 million. The government is mulling over a proposal to further lower the minimum threshold limit for standalone health insurance companies to US$ 5.6 million.

for bringing industrial tariffs down and has been doing so unilaterally. It now argues for keeping agricultural protection high. Take the draft text circulated in January 2008. The feeling is that the measures suggested both under the agriculture text and the Non Agricultural Market Access (NAMA) do not suit India's interests. For industrial tariffs, India would have to cut down duties substantially.19 But while the text is being debated, the familiar arguments are out – why should developing countries cut down tariffs drastically while the developed ones only make marginal reductions.[20]

In India, the debate on International trade has been and continues to be a debate on globalisation.[21] Those who oppose trade on the infant industry argument argue

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19 Which, if one looks at the tariff structure prevailing in the country, should be brought down in any case? And it is a matter of time that these are brought down to ASEAN levels unilaterally.

20 On agriculture, India finds the US offer of cutting down subsidies by a fourth not sufficient. It is also unhappy with the manner in which tariff escalation provisions neglect India's key areas of exports in milk and milk products, meat and met products, mangoes and other fruits.

21 It is ironic that the debate against trade rages in a country that has been the pioneer of trade across borders and has historically been both a supplier and a market of foreign goods. On the Elephanta islands off Mumbai, Roman pottery findings have highlighted a flourishing trade between the Roman and the Indian civilization between the 4th and the 7th century AD. Trade with Oman had been going on form the 1st century and continued till well into the 13th century A. India's trade was also greatly diversified, it traded with Japan, with China and the Red Sea countries. The silk route saw India's silk and ivory reaching various parts of the world. The Spice route brought in Oman money into India, established again by a major finding of more than 60000 Roman coins along the Cauvery river along the Spice Route.

that small businesses cannot compete with large foreign firms. They also argue that imports lead to a shift of production away from indigenous source and therefore cause unemployment. Further, it is argued that free trade leads to dumping of poor quality goods from across the border. These goods are harmful to health and the environment. Also, reliance on imports leads to dependence on foreign countries that then exploit their economic advantage for political benefit. Free trade leads to free flow of currency and this makes domestic economies vulnerable to the whims of foreign investors and causes crises like seen in Latin America and East Asia. However, free trade not only benefits the countries involved but results in higher returns for the entire world.

Free trade results in the globalisation of production and consumption. It allows countries to leverage their comparative advantages and produce goods and services that they are relatively more efficient in producing. Countries can then specialize and therefore world production on the whole improves. Globalisation has indeed helped developing and poor countries leverage their abundant resources to produce goods and services that allow for foreign exchange earnings that can then be used for essential imports. Also, free trade has improved the chances of the really poor countries to conduct business internationally, allowing their firms to widen their portfolios and enter large markets. It is in this context that domestic policies on trade assume significance and political mindset prevails over issues such as import

restrictions, export regulations, tariffs and duties.[22]

Historically in India. the prime urban centres of economic activity were Agra, Delhi, Lahore, Multan, Thatta and Srinagar in the north23. The important cities in the west included Ahmedabad, Bombay, then known as Khambat, Surat, Ujjain and Patan. In the east Dacca, Hoogli, Patna, Chittagong and Murshidabad were centres of trade. These were large and well populated cities. Textile trade was critical too. Gujarat exported cotton to Arabia to South- East Asia. Silk and natural colour dyes were exported to Malaysia, Indonesia, and the Philippines. From the East, the indigenous varieties of silk like tussar and munga along with cotton and jute were exported. Kasimbazaar in Bengal was an important trade centre. In the South, it was Malabar in Kerala that produced and exported coloured and printed cloth material. Golconda's Kalamkari, painted cotton fabrics with motifs from Hindu mythology were exported through the port city of Masulipatnam.

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[22] It is important for politics in various countries to understand that unrestricted free trade and the free exchange of goods, services and human resources leads to a convergence in prices and stability across the world. Trade becomes a substitute for migration and allows poor countries to earn higher amounts of money for the factor that they are abundant in. Protectionism actually hurts the consumer as local prices rise and hurts domestic manufacturers as they are unable to get raw material from the cheapest sources. It is crucial for world economic growth that free trade be encouraged without restriction.

[23] This is during the time India lays claims to being the richest empire in the world in the 15th and 16th century.

In the recent past, especially in the last three years of so, there has been a surge of dollars coming into the Indian economy by way of export earnings, foreign direct investments, portfolio investments and Non Resident Indian (NRI) repatriation. This has fuelled an unprecedented supply of dollars leading to the steady fall in the value of the dollar. A large number of foreign institutional investors (FIIs) are now putting their money into India's capital markets. NRIs had already made India the largest recipient of non resident repatriation by sending more than 50 billion dollars. India was traditionally a country that foreign investors and multinational corporations avoided. Even after the open door policies, low interest rates and fast paced economic growth, the flow of Foreign Direct Investment (FDI) was slow despite the fact that other developing countries witnessed a rising trend in the last decade. India was among the lowest recipients of FDI among developing countries until 1970s.

What seems to have worked is the fact that India entered into a number of investment treaties and double taxation avoidance agreements with a large number of countries. Also, India's rising domestic income makes it a large market and its trained work force makes it an ideal manufacturing centre. With the exception of mining, agriculture and the retail sectors, India has opened up its economy significantly and that is the reason it has become such a favourite of the foreign investors. Also India has become the favourite destination of US foreign

investment.[24] Till the 1990s it was Europe that invested in India. In the recent past, the US has started looking at India and a large number of American firms have invested here – These include AT&T, General Electric, General Motor, Ford, IBM Corp, Motorola, Mobil, Pepsi and Exxon. Most investment comes into three different sectors- infrastructure, consumer goods and oil.

It is not surprising that the Federal government through its annual Economic Survey has advocated the liberalizing of foreign direct investment (FDI) for services such as health insurance, rural banking and higher education. Relaxation in FDI policy to this effect would create a more conducive environment for trade in services, the government admits. The agriculture services sector attracted FDI of Rs 6,327 crore between April and November of FY10 against a mere Rs 16 crore recorded in the year ago period. In the case of the sea transport sector, FDI inflows rose to Rs 1,293 crore against Rs 127 crore in the same period of the previous year. For electrical equipment, the FDI inflows stood at Rs 2,724 crore against Rs 900 crore. The services sector accounted for the highest FDI flows; the foreign investment inflows touched

[24] In the decade of the 70s, the total cumulative inflow of FDI was about US$450 million amounting to 0.20% of gross domestic investment. India started opening up its market from July, 1991 by lowering tariff and non-tariff barriers (NTBs), and liberalizing investment policies. Its openness is still not complete and it remains among the more protected of the emerging economies. Infrastructure continues to be of lesser quality compared to any of the East Asian and Latin American economies it competes with. The surge in FDI in the last two years, despite such problems is indeed remarkable.

Rs 16,566 crore between April and November FY10 against Rs 15,919 crore in the year-ago period. Other sectors that raked in a significant chunk of FDI were telecom, housing and real estate, and construction. The total FDI equity inflow during the period was Rs 93,354 crore, a growth of 9 per cent from Rs 85,700 crore in the year ago period.

The Health care reform in the US and lessons for India

The US President has suddenly won a major battle he has been fighting with his own countrymen. The world's most powerful country now has a health care mechanism that will include almost the entire population and no longer will nearly 35 million people stay outside the formal health system and suffer on account of health cover not available to them. It is time now to take a look at what we are doing to our health care system in India. To put it simply, the health care system in India is more or less absent and a bulk of the population has no access to quality health facilities. The state machinery is absent in most parts and health care needs are met by the private sector which often comprises resources of dubious quality. The story is stark and the data gruesome. At least between 2/3rds to 3/4ths of all medical expenditure is spend on privately provided care every household on the average spends up to 10% of annual household consumption in meeting health care needs. The single biggest factor contributing to chronic poverty in India is expenditure on health care. Two and a half million suffer from HIV/AIDS. What is worse is that annually 22 lakh infants and children die from preventable illnesses; 1 lakh mothers die during child birth,

5 lakh people die of Tuberculosis. Diarrhoea and Malaria continue to be killers across the country.

There is so much that needs to be done. The Medical Council of India does precious little about doctors prescribing frivolous tests. It turns a blind eye to educational institutions of dubious quality. It does not seem to mind the fact that there is a huge shortage of specialists in the profession, despite more than 250 medical colleges operating across the country. It can find no way of retaining doctors in rural areas and when pushed against the wall, comes up with staid and clichéd dictates on compelling doctors to work in villages. The US debate has surely made people more aware of health care issues. Access to quality health care is a right that citizens have and this access cannot be postponed just because a powerful health insurance lobby or a pharmaceutical lobby does not want this to happen.

Conclusion

In the current debate on health security for the poor, health insurance is made out to be panacea for all the ills facing the poor. Health insurance, no doubt, has emerged as an important financing tool as it promises to mobilize some resources from the people themselves i.e., those who buy insurance. But health insurance, which strengthens demand side, makes sense only when the supply of health care is reasonably well developed. Where this is not so, health insurance is meaningless. The supply of health care in the rural and remote areas of country is far from satisfactory. Although public health care centers

are pervasive, these centers have degraded overtime in most states due to lack of funds, accountability and so forth. Any attempt at introducing health insurance for the poor must also be accompanied by revival of health care facilities at these centers. Finally, both the provision and access to health care services should be a part of a bigger health strategy which includes other public health programs such as safe drinking water, sanitation, family planning etc. as each of these are important determinants of health outcomes.

Since January 2000, FDI is permitted up to 100 percent under the automatic route in hospitals in India. Controlling stake is also permitted in hospitals for foreign investors. FIPB approval is only required for foreign investors with prior technical collaboration, but allowed upto 100 percent. Current regulations also permit other forms of capital mobilization, such as through ADRs and GDRs, upto 49 percent, which are treated as FDI. FII as well as private equity funding over a certain stake are also permitted under FDI route. In addition, FIIs and private equity funds can individually purchase upto 10 percent and collectively upto 24 percent of the paid-up share capital of the company, through open offers or private placement, or through the stock exchange. Proprietary funds, foreign individuals and foreign corporates can register as a sub-account and invest through the FII, subject to limits of 10 percent and 5 percent, respectively for these sub-accounts. Foreign venture capital investments (FVCIs) are also permitted, though subject to certain restrictions.

Insurance is a mode 1 service that occurs through cross border supply, the provision of health-insurance services (primarily through modes 3 and 1) by foreign companies could have an important impact on the sustainability of the domestic health systems and facilitate access to health service. Increasing liberalization of this sector would have several impacts on access to health care within the country and the growth of the sector itself. There could be positive externalities in other areas, some of which could further drive foreign investment in health care.

There is likely to be closure of substandard institutions, some consolidation of the health insurance segment, and new kinds of arrangements could emerge between larger and smaller players as the healthcare sector evolves. There could be greater segmentation between the public and private sector with resource flows towards the latter, greater wage disparity, unless innovative arrangements emerge between the two segments and reforms are undertaken in the public sector firms. They are likely to employ a higher ratio of technology to personnel in their delivery and thus involve a substitution of human resources with technology and equipment.

India should indeed liberalize its offer on health insurance to 100 percent with no prior approval requirement, i.e., bind in its existing FDI regulations in this area. Several studies suggest that India could bind in its existing FDI policy in hospitals and healthy insurance and permit 100 percent on automatic route. The justifications

for such a strategy relate to two facts. First, as investors see a lack of clarity and roadmap for the health sector, a binding commitment would signal that the liberal foreign investment policy for hospitals is there to stay and that the government is committed to facilitating investments in India's hospital segment. Second, to the extent that additional FDI does flow into hospitals and insurance, there are several likely benefits that could accrue while the negatives that could arise will not really be a direct result of foreign investment but of existing structural distortions and inadequacies in India's health care sector.

Opening up the health insurance sector to enable greater scrutiny of processes and standards of hospitals would also help attract foreign funds, as well as introduction of a national or community based health insurance scheme to increase affordability of healthcare and mitigate potential adverse effects of corporatisation on equity. It would also help in improving the regulatory framework for health insurance by standardizing norms for payouts, coverage, reduce malpractice; and the establishment of a regulatory framework and an independent regulator in the healthcare sector to address issues of standardization, classification, information disclosure, etc. Finally, the involvement of private insurance networks in health insurance conventions could help remove the ultimate obstacle to trade in health services: the absence of health insurance portability.

References:

1. Berman P.A. (1997): '*Rethinking Health Care Systems: Private Health Care Provision in India*' Harvard School of Public Health, July
2. Berman, P; (1996), "*Health Care Expenditure in India*" in Monica Dasgupta et al (Eds), Health, Poverty and Development in India, Oxford University Press, Delhi.
3. Berman, P; Khan M.E (eds), "*Paying for India's Health Care*", Sage Publications, New Delhi, 1993
4. Bhat, R; 1996; "*Regulation of the Private Health Sector in India*", International Journal of Health Planning and Management, 11:253-74
5. Burgess, R.; Stern, N. (1991): Social Security in Developing Countries: What, Why, Who, and How? In: Ahmad, Drèze, Hills, Sen (eds.): Social Security in Developing Countries. Wider Studies in Development Economics. Clarendon Press, Oxford, pp. 41-80.
6. Business World, cover story, October,1999
7. Central Statistical Organization, "*Selected Socio-Economic Statistics, India 2001*", Ministry of Statistics and Programme Implementation, Government of India. 2003.
8. Charu Garg (1998); "*Equity of Health Sector Financing and Delivery in India*", Takemi Working Papers, Harvard School of Public Health.
9. Chollet, D. J.; Lewis, M. 1997. "Private insurance: Principles and practice", in Innovations in health care financing. Washington, DC, World Bank.
10. Duggal R. (1993): "*Employee Medical Benefit in Corporate Sector*" The Foundation for research in Community Health, Bombay.

11. Duggal, R; Amin, S; "*Cost of Health Care: A household Survey in an Indian district*". The Foundation for Research in Community Health, Bombay, 1989
12. Economic Survey, 2002-2003, Government of India, Ministry of Finance & Company Affairs, Economic Division.
13. Giridhar, G; "Concepts and Practices in Health Care nsurance Schemes and Reent Examples in India". Paying for India's Health Care. Eds: Berman & Khan. Sage Publications, 1993.
14. Griffin, C.; Shaw, P. R. 1995. "Health insurance in sub-Saharan Africa: Aims, findings, policy implications", in P. Shaw and M. Ainsworth, Financing health services through user fees and insurance. Washington, DC, World Bank.
15. Jesani, A; Anantharam, S, 1989; "*Private Sector and Privatization in the Health Care Service"*, Bombay, Foundation for Research in Community Health.
16. Jutting, J. (1999): Strengthening Social Security Systems in Rural Areas of Developing Countries. ZEF Discussion Paper on Development Policy. Center for Development Research, Bonn.
17. Outreville, J. F. 1998. "The health insurance sector: Market segmentation and international trade in health services", in S. Zarrilli and C. Kinnon (eds.), International trade in health services. Geneva, UN, WHO. Review, 53 [5], pp. 941-973.
18. Ron, A.; Abel-Smith, B.; Tamburi, G. 1990. Health insurance in developing countries. Geneva, ILO.

19. Sanyal S.K. (1996); "*Household financing of health care*", Economic and Political Weekly, Vol. XXXI, May.
20. Shariff, A. (1995), "*Health Transition in India*", Working paper no. 57, National Council of Applied Economic Research, New Delhi.
21. Uplekar, M; "*Private Doctors and Public Health*", Takemi Program in International Health, Report No. 40, Harvard School of Public health, 1989
22. Viswanathan, H; Rohde, J.E; "*Diarrhoea in rural India: A nationwide Study of Mothers and Practitioners*", New Delhi
23. WHO. 1978. Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978. Geneva
24. Williams, A. 1997. "Priority setting in public and private health care", in A. J. Cuyler and A. Maynard. (eds.), Being reasonable about the economics of health.
25. World Bank (1993) "*World Development Report: 1993, Investing in Health*" New York, Oxford University Press.
26. World Bank 1995; "*India: Policy and Finance Strategies for Strengthening Primary Health Services*", Report No. 13042, Population and Human Resources Division, Washington D.C.